



DATE: _____ PATIENT NAME: _____ SS # _____

ADDRESS: _____

HOME PHONE: _____ DATE OF BIRTH: _____

Emergency contact: _____ Relationship: _____ Phone: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical benefits to Medical Associates of the Hudson Valley, P.C. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I authorize Medical Associates of the Hudson Valley, P.C. to furnish information to my insurance carrier(s) concerning illness and treatments received by me.

MEDICARE PATIENTS ONLY:

I authorize any holder of medical or other information about me to release any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

PATIENT SIGNATURE: _____ DATE: _____

PATIENT NAME (PLEASE PRINT) _____ DATE: _____

INSURANCE AND BILLING INFORMATION

Please present insurance card to front desk personnel upon check in.

Patient's Employer: _____ Phone: _____

Employer's Address: _____

Name of insurance carrier: _____ Address: _____

Policy ID#: _____ Group#: _____ Plan#: _____

Policy holder: _____ Policy holder date of birth: _____

Name of insurance carrier: _____ Address: _____

Policy ID#: _____ Group#: _____ Plan#: _____

Policy holder: _____ Policy holder date of birth: _____

******If auto or work related, please see receptionist for appropriate forms.***

HIPAA ACKNOWLEDGEMENT

I, _____, acknowledge that I have been provided with a copy of MEDICAL ASSOCIATES OF THE HUDSON VALLEY, PC's Notice of Privacy Practices and have been given an opportunity to read and ask questions about the Notice.

Please circle one:

May we leave a message regarding an upcoming appointment on:

Answering machine at home?	YES or NO	Office voice mail?	YES or NO
W/Another person?	YES or NO	Send through mail?	YES or NO
Send through email?	YES or NO		

May we leave other medical information on:

Answering machine at home?	YES or NO	Office voice mail?	YES or NO
W/Another person?	YES or NO	Send through mail?	YES or NO
Send through email?	YES or NO		

Person(s) authorized to discuss the above?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Date: _____ Patient's Signature: _____

